REQUEST TO AMEND PROTECTED HEALTH INFORMATION BY PARENT, GUARDIAN OR PERSONAL REPRESENTATIVE

File Number: _____

You have the right to request amendments to protected health information which the Cancer Detection Section creates or maintains. We will act upon your request to amend within 30 days of our receipt of your request. If your request is denied, we will let you know the reasons for the denial in writing. You have the right to disagree with our denial of your request for amendment. You may tell us why in a written statement of disagreement that will be added to your record. If we continue to disagree with your requested amendment, we may place a note (rebuttal statement) in the record stating why we do not agree with your statement of disagreement. We will send you a copy of our rebuttal statement. You also have the right, under the Information Practices Act of 1977, to request a review of the refusal to amend a record by the head of the agency or a designee. Mail this completed form, with a photocopy of your identification (see Page 3) and additional documentation of your address if required (see Page 3), to:

Cancer Detection Section
Attention: HIPAA Manager
MS-7203, P.O. Box 997413
Sacramento, CA 95899-7413

INDIVIDUAL WHOSE INFORMATION YOU ARE AMENDING		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:
Cancer Detection Programs: Every Woman Counts RECIPIENT ID NUMBER*	DATE OF BIRTH:	SOCIAL SECURITY NUMBER*

*We use these numbers to make sure information is amended only by appropriate persons.
If you don't supply at least one of the numbers, we will be unable to honor your request. You can get your Recipient ID Number from the place where you received medical services paid for by the Cancer Detection Programs: Every Woman Counts.

PARENT, GUARDIAN, OR PERSONAL REPRESENTATIVE INFORMATION		
LAST NAME:	FIRST NAME:	MIDDLE INITIAL:
ADDRESS:	CITY/STATE:	ZIP CODE:

DAYTIME PHONE NUMBER	ALTERNATE PHONE NUMBER	BEST TIME TO REACH YOU	EMAIL ADDRESS
( ) _____	( ) _____	_____	_____

WHAT LEGAL AUTHORITY DO YOU HAVE TO REQUEST THE HEALTH INFORMATION OF THE INDIVIDUAL ABOVE?

☐ PARENT ☐ CONSERVATOR

☐ GUARDIAN ☐ EXECUTOR OF WILL

☐ MEDICAL POWER OF ATTORNEY ☐ OTHER

PLEASE ATTACH LEGAL DOCUMENTATION VERIFYING THAT YOU ARE THE PARENT, CONSERVATOR, GUARDIAN, EXECUTOR OF A WILL, OR HAVE MEDICAL DECISION-MAKING AUTHORITY FOR THE INDIVIDUAL. EXECUTORS MUST ATTACH A DEATH CERTIFICATE.

PROTECTED HEALTH INFORMATION YOU WANT TO AMEND

IDENTIFY THE PROTECTED HEALTH INFORMATION IN THE INDIVIDUAL'S CANCER DETECTION SECTION RECORD YOU WANT AMENDED:

WHAT YOU WANT THE RECORD TO STATE NOW: (ATTACH ADDITIONAL PAPER IF NECESSARY)

STATE THE REASON YOU BELIEVE THE AMENDMENT SHOULD BE MADE:

IDENTIFYING INFORMATION

☐ COPY OF PHOTO IDENTIFICATION ATTACHED

ACCEPTABLE IDENTIFICATION IS A CALIFORNIA DRIVER'S LICENSE, CALIFORNIA DMV IDENTIFICATION CARD, PASSPORT, MATRICULA CONSULAR OR STATE OR FEDERAL EMPLOYEE ID CARD.

I DECLARE UNDER PENALTY OF PERJURY THAT THE INFORMATION ON THIS FORM IS TRUE AND CORRECT.

REPRESENTATIVE SIGNATURE: DATE:

☐ **IF NO PHOTO IDENTIFICATION IS ATTACHED, YOUR SIGNATURE MUST BE NOTARIZED.**

NOTARIZED BY _____ ON _____ (DATE)

NOTARY PUBLIC NUMBER _____

UNOFFICIAL UNLESS STAMPED BY NOTARY PUBLIC

☐ IF THE PHOTO IDENTIFICATION DOESN'T SHOW THE ADDRESS ON PAGE 1 OF THIS FORM, PLEASE PROVIDE A PHOTOCOPY OF ONE OF THE FOLLOWING TO CONFIRM YOUR PRESENT ADDRESS: UTILITY BILL, PHONE BILL, DRIVER'S LICENSE, ETC.

NOTE: ANY ATTEMPT TO FALSELY GAIN ACCESS TO PROTECTED HEALTH INFORMATION IS SUBJECT TO LEGAL PENALTIES.

DHS is committed to protecting the information you provide us. To prevent unauthorized access or disclosure, to maintain data accuracy, and to ensure the appropriate use of the information, DHS has in place appropriate physical and managerial procedures to safeguard the information we collect.